New Trends in Health Care

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Blue Cross and Blue Shield of Montana

BlueCross BlueShield of Montana

Agenda

Welcome
Affordable Care Act
Addressing Health Care Costs
Future Trend

Affordable Care Act

A Transformative Era

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Unprecedented Times

- Transformative and unprecedented era
  - 2014 an historic year
    - ACA implemented
      - Individual mandate, penalties
      - Federal and state-based exchanges
      - Employer mandates, penalties delayed
    - With excitement came challenges
      - www.healthcare.gov
      - Data sharing between CMS, health insurers caused confusion
      - Shifting rules and deadlines
  - 2015 expected to be another record year

ACA Refresher

- Guaranteed issue to all applicants
- No pre-existing condition exclusions
- 4 rating criteria
  - Age, Geographic Location, Tobacco, # Lives
- No coverage waiting periods longer than 90 days
- No annual limits on “essential benefits”
- Preventive coverage at 100%
- Mandate to have/offer coverage
- Subsidies available
  - Household income between 100%-400% of FPL
  - Penalties apply

Exchange Subsidies

Two forms of financial assistance are available to help lower income people pay for private health insurance obtained through the Marketplace:

1. “Premium tax credits” to help pay insurance premiums
2. “Cost-sharing caps” which limit the maximum out-of-pocket spending on deductibles, co-pays and benefits.

- Subsidies are only available for health insurance purchased through the Marketplace.

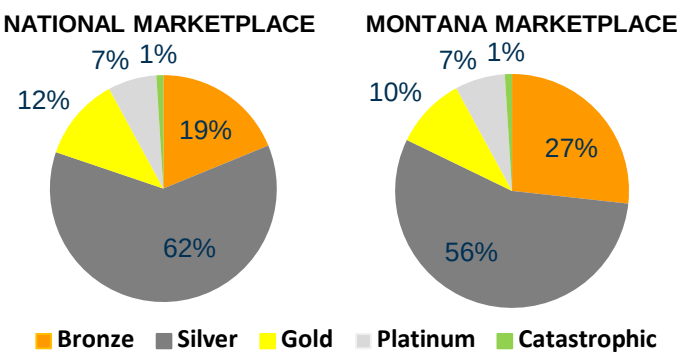
2015 Subsidies

- Individuals with income below $46,680
- Couples earning less than $62,920
- Families of four earning less than $95,400
- Families of five earning less than $111,640

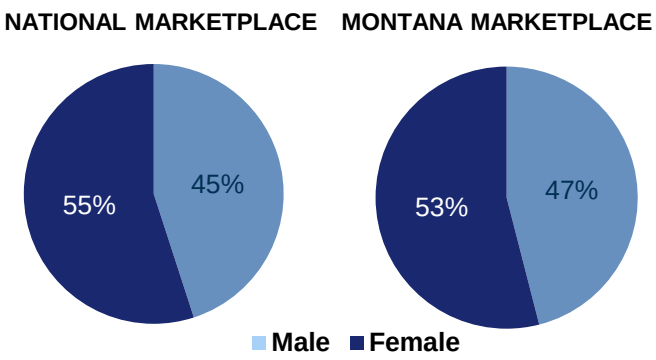
2014 Enrollment

Statewide enrollment on the federal Marketplace was **36,584**.

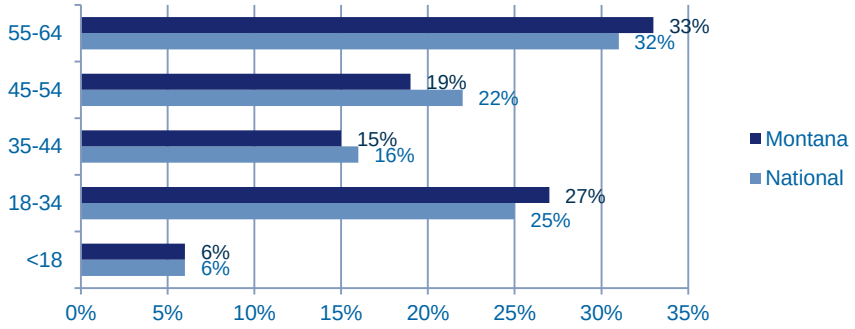
Plan Selection by Metal Level



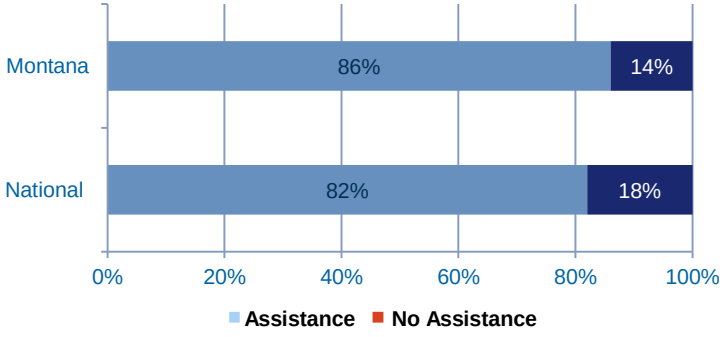
Plan Selection by Gender



Plan Selection by Age



Plan Selection by Financial Assistance Status



- **Enrollment numbers are total Marketplace figures. Figures cover enrollment from 10/1/13 to 04/15/14.**
- ***Source: HHS***

2014 Enrollment

Total Individual Market enrollment*

- 60,000 total individuals in Montana
  - On and Off the Exchange
- BCBSMT 42,000
  - 20,000 on Exchange, 22,000 off
- MT Health Co-Op 12,500
  - 11,000 on Exchange, 1,500 off
- PacificSource 7,200
  - 5,000 on Exchange, 2,200 off

***Numbers as of 4/15/14**

Where are we going?

- Slower than expected enrollment
  - Uninsured rate in Montana is 16.8%
    - That's approximately 175,000 Montanans without insurance
    - Some of uninsured fall into the Medicaid gap
- Ongoing political debate, media spotlight

Employer Mandate (ESR)

Last year, the Federal Government delayed full implementation of the ACA, in particular the Employer Shared Responsibility (ESR) for large groups of more than 50 full-time equivalent positions.

The current rollout timeline is:

- 2-49 FTE — No Mandate
- 50-99 FTE — January 1, 2016
- 100-plus FTE — January 1, 2015

Employer Mandate (ESR)

There are two ways in which employers may be penalized.

General Penalty Criteria:

- Employer has more than 50 FTEs (excluding seasonal workers)
- One or more eligible employees purchase subsidized coverage through exchange

1. Employer Does not Offer Coverage:

- Employer is penalized for all full-time employees excluding the first 80
- No penalty for part-time workers

2. Employer Offers Unaffordable Coverage:

- Employer is penalized if cost of self-only coverage exceeds 9.56% of an employee's income or the plan covers less than 60% of healthcare expenses

No Coverage Penalty:

- Penalty is assess for every full-time employee

$2,000 (per FTE)
Note: Penalty is levied as excise tax, if taxable employer it must pay penalty after tax
$2,000 + ($2,000 x 39%) = $2,780

Unaffordable Coverage Penalty:

- Penalty is assessed for each eligible employee that obtains subsidy on Exchange

$3,000 (per FTE obtaining subsidies)
Note: Penalty is levied as excise tax, if taxable employer it must pay penalty after tax
$3,000 + ($3,000 x 39%) = $4,170

Employer Mandate (ESR)

- Information Reporting
  - Applicable large employers, health insurers and health plan sponsors must:
    - **REPORT** certain health insurance coverage information to the IRS annually; and
    - **REPORT** all related annual information on individuals who receive Exchange coverage
    - Large Employers: 6056 (up to employers to report)
    - Health plan sponsors, health insurers: 6055 (**BCBSMT will report for insured groups but not for ASO groups**)
  - Exchanges must:
    - REPORT information on individuals, plan premiums, tax credits received, etc.

Employer Mandate (ESR)

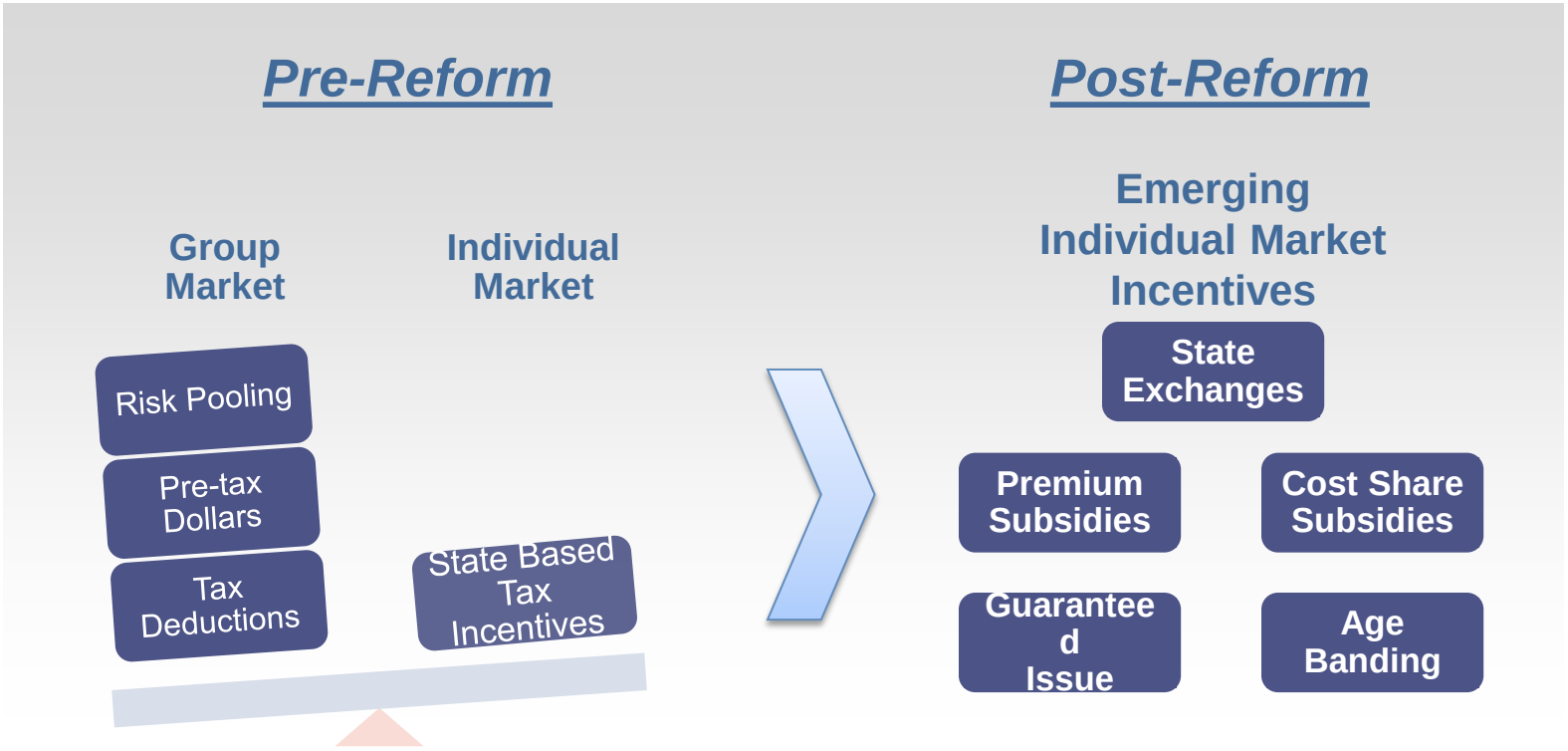
- Why Information Reporting?
  - True up information
    - Which employees are eligible for subsidies on the Exchange?
    - Which employees received a subsidy and how much?
    - Which large employers offer affordable coverage?
- Who must report?
  - Employers with 50-99 FTEs (even if qualify for one-year delay of mandate)
  - Employers with 100+ FTEs who must comply with mandate
- When are these reports due?
  - Effective for 2015 (voluntary for 2014)
  - Due to IRS March 1, 2016
  - Annual statements to employees due Feb. 1, 2016
  - Link to forms:
    - http://apps.irs.gov/app/picklist/list/draftTaxForms.html

Employer Mandate (ESR)

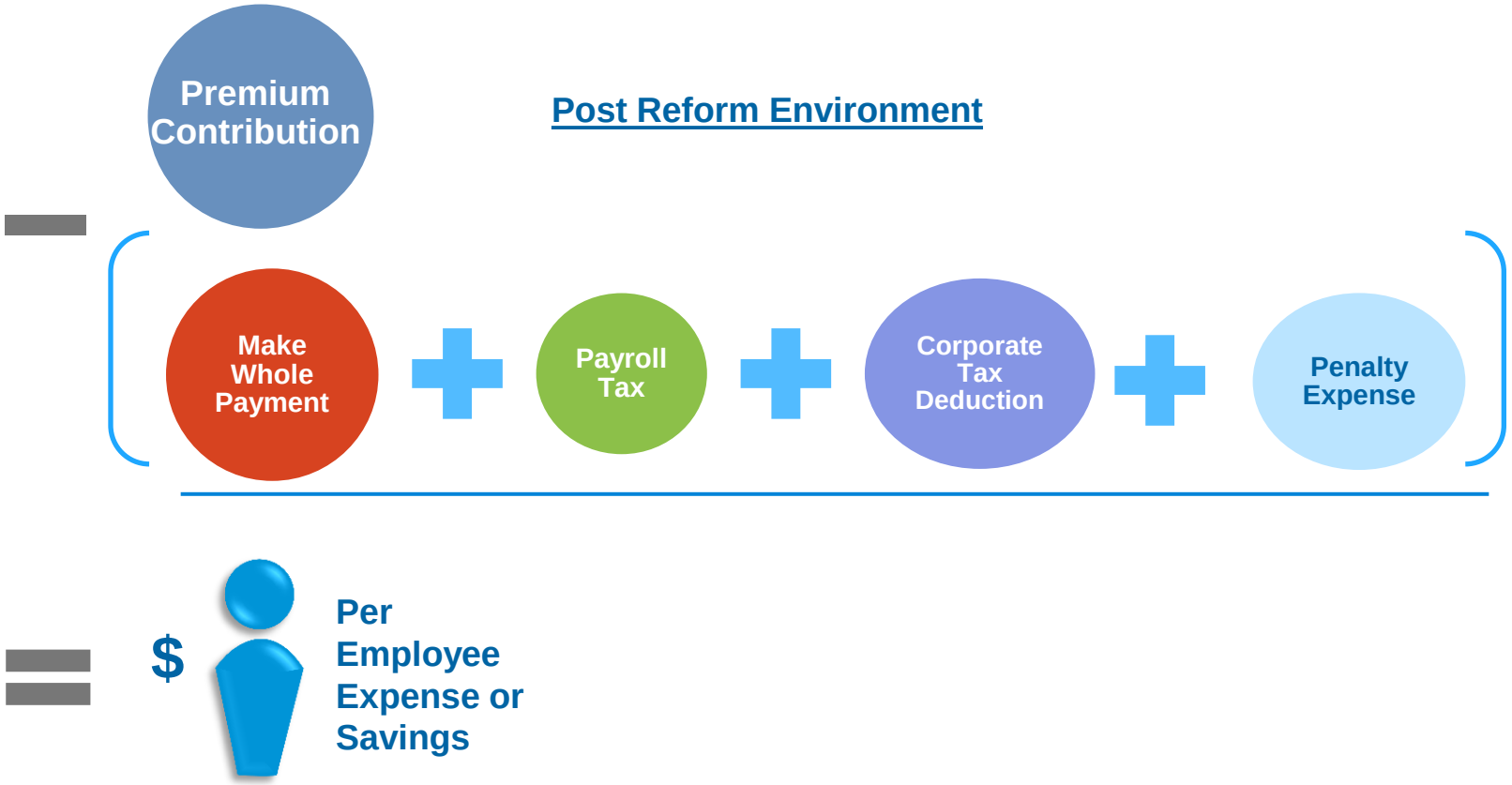
- Get prepared
  - Who measures 6056 information?
  - Where is the data coming from?
  - Who will report?
  - Who will track?
- Good opportunity for you to get out front of changes with a trusted message

Evaluating Economic Factors

Changes in consumer incentives to purchase in the individual market may change employers' value proposition to offer coverage



Financial Impact Evaluation



Controlling Costs

Managing the Drivers of Overall Cost

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Controlling Costs

- Rationale for health care reform
  - "I am an automotive diagnostician. We look for the root cause of problems. If we treat the symptoms, the problem always comes back. With health care, we are not treating the root cause: Why does it cost so much?"
    - Donny Serfer, as told to the New York Times

Analyzing Costs

- Treatment of chronic diseases
  - Hypertension, diabetes, obesity
  - Many are preventable, others are not
  - Cause 7 in 10 deaths each year in U.S.
  - Account for ¾ of the $2 trillion-plus spent each year on medical care in the U.S.
  - 16% of the population accounts for 80% of medical care
- Prescription drugs, advances in medical technology, fraud, waste, threat of malpractice
- Cost-shifting
- Uncompensated and undercompensated care

Addressing Health Care Costs

- Negotiated Discounts
- Medical Management (Care Coordination)
- Patient-Centered Medical Home (PCMH)
- Technology
- Transparency
- Fighting Fraud

Care Coordination

Integrated Predictive Modeling Opportunity Score drives member to appropriate program

HEALTHY | AT RISK | CHRONIC CONDITIONS | COMPLEX CONDITIONS

- Well on Target℠
- Health Assessment
- Total Health Management
- Preventive Care Initiatives
- Member Portal and Online Tools
- 24/7 Nurseline
- Behavioral Health
- Lifestyle Management
- Utilization Management
- Special Beginnings® Maternity Program
- CCEI℠ Care Coordination & Early Intervention
- Condition Management
- Case Management

Blue Care® Advisors

< < < Strong provider partnerships in collaborative care initiatives > > >

Patient-Centered Medical Home (PCMH)

- Incentivizes an engaged relationship between provider and consumer
- Proactive management of patient care
- Significantly reduces ER visits, re-hospitalizations
- Improves frequency of visits with primary care physician
- Preventive care is typically covered 100%

Wellness

- Rewards success, not just participation
- Provides strong financial incentives for:
  - Completing preventive care
  - Controlling weight, blood pressure, cholesterol
  - Being tobacco-free
- Identifying risks before they become bigger issues
- Happier, more productive employees

Consumer-Friendly Tools

- Integrated Provider Finder / Member Liability Estimator

Now easier than ever to find a provider that's right for you.

- **Results by provider type, specialty, network, language and nearby urgent care centers**
- **Directions from Google Maps™**
- **Quality certifications and recognitions for doctors, hospitals, dentists and optometrists**
- **Online or Mobile**

Fighting Fraud

- Medicare scams alone are estimated at $60 billion per year
- State, federal government
  - U.S. and state Departments of Justice
  - State Auditor's Office
- Insurers
  - Through an aggressive anti-fraud program, BCBSMT has recovered millions in fraudulent claims

Networks

In-network

- Highest level of benefits
- Provider discounts
- Provider files claims

Out-of-network

- Member pays more of the cost
- No provider discounts
- Member may have to file claim manually

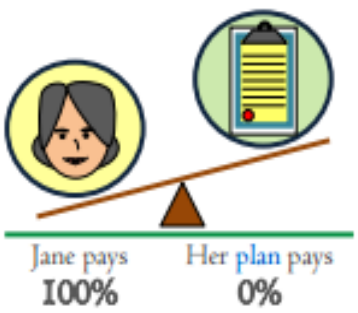
Plan Example

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

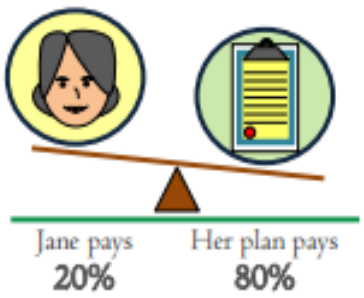


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

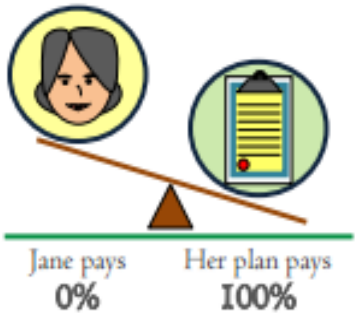


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



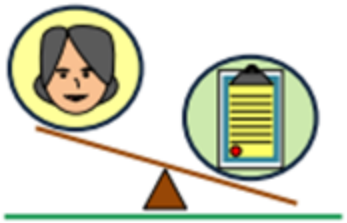
Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

In-Network vs. Out-of-Network

Jane's Plan Deductible: $1,500 **Coinsurance: 20%** **Out-of-Pocket Max: $5,000**



In-Network	
Charge	$50,000
Allowed Amount	$40,000
Insurance coverage @ 80%	– $32,000
Patient Responsibility	= $8,000

Out-of-Network	
Charge	$50,000
Allowed Amount	$40,000
Insurance coverage @ 60%	– $24,000
Patient Responsibility	= $16,000

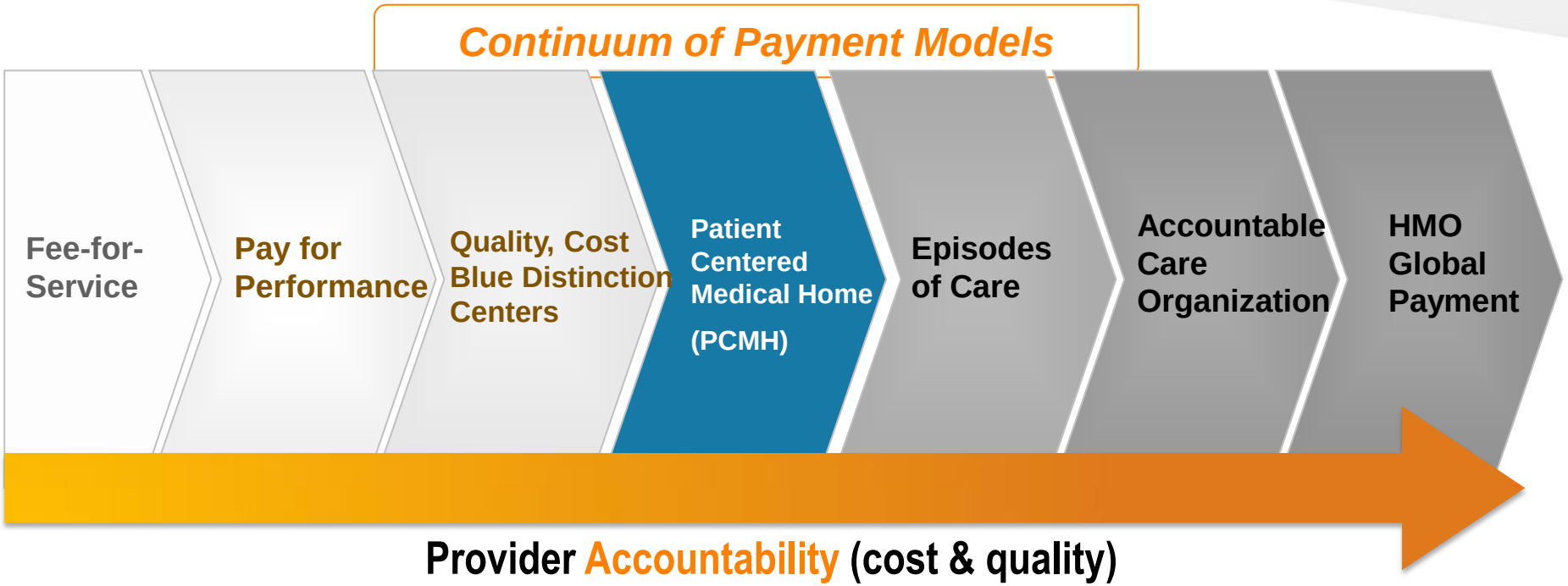
OOP maximum **$5,000**

In addition, there would be a $10,000 balance billing charge.

Patient Responsibility: $5,000

Patient Responsibility: $26,000

Future of Health Care



Increase the value of health care services by transforming care delivery.

- Driven by:
  - Transparency
  - Analytics

Questions?

Thank you!